Medicare provider of services as defined in § 400.202 of this chapter.

(4) Diagnostic x-ray tests and other diagnostic tests (excluding diagnostic laboratory tests paid under the fee schedule established under section 1833(h) of the Act).

(5) X-ray, radium, and radioactive isotope therapy, including materials and services of technicians.

(6) Antigens, as described in section 1861(s)(2)(G) of the Act.

(7) Bone mass measurement.

RVU stands for relative value unit.

(8) Screening mammography services.

[56 FR 59624, Nov. 25, 1991, as amended at 57 FR 42492, Sept. 15, 1992; 58 FR 63686, Dec. 2, 1993; 59 FR 63463, Dec. 8, 1994; 60 FR 63177, Dec. 8, 1995; 63 FR 34328, June 24, 1998; 66 FR 55322, Nov. 1, 2001; 75 FR 73616, Nov. 29, 2010]

§ 414.4 Fee schedule areas.

(a) *General.* CMS establishes physician fee schedule areas that generally conform to the geographic localities in existence before January 1, 1992.

(b) *Changes.* CMS announces proposed changes to fee schedule areas in the FEDERAL REGISTER and provides an opportunity for public comment. After considering public comments, CMS publishes the final changes in the FEDERAL REGISTER.

[59 FR 63463, Dec. 8, 1994]

§ 414.5 Hospital services paid under Medicare Part B when a Part A hospital inpatient claim is denied because the inpatient admission was not reasonable and necessary, but hospital outpatient services would have been reasonable and necessary in treating the beneficiary.

(a) If a Medicare Part A claim for inpatient hospital services is denied because the inpatient admission was not reasonable and necessary, or if a hospital determines under § 482.30(d) of this chapter or § 485.641 of this chapter after a beneficiary is discharged that the beneficiary's inpatient admission was not reasonable and necessary, the hospital may be paid for any of the following Part B inpatient services that would have been reasonable and necessary if the beneficiary had been treated as a hospital outpatient rather than admitted as an inpatient, provided the beneficiary is enrolled in Medicare Part B:

(1) Services described in § 419.21(a) of this chapter that do not require an outpatient status.

(2) Physical therapy services, speech-language pathology services, and occupational therapy services.

(3) Ambulance services, as described in section 1861(v)(1)(U) of the Act, or, if applicable, the fee schedule established under section 1834(l) of Act.

(4) Except as provided in § 419.2(b)(11) of this chapter, prosthetic devices, prosthetics, prosthetic supplies, and orthotic devices.

(5) Except as provided in § 419.2(b)(10) of this chapter, durable medical equipment supplied by the hospital for the patient to take home.

(6) Clinical diagnostic laboratory services.

(7)(i) Effective December 8, 2003, screening mammography services; and

(ii) Effective January 1, 2005, diagnostic mammography services.

(8) Effective January 1, 2011, annual wellness visit providing personalized prevention plan services as defined in § 410.15 of this chapter.

(b) If a Medicare Part A claim for inpatient hospital services is denied because the inpatient admission was not reasonable and necessary, or if a hospital determines under § 482.30(d) of this chapter or § 485.641 of this chapter after a beneficiary is discharged that the beneficiary's inpatient admission was not reasonable and necessary, the hospital may be paid for hospital outpatient services described in § 412.2(c)(5), § 412.405, § 412.540, or § 412.604(f) of this chapter or § 413.40(c)(2) of this chapter that are furnished to the beneficiary prior to the point of inpatient admission (that is, the inpatient admission order).

(c) The claims for the Part B services filed under the circumstances described in this section must be filed in accordance with the time limits for filing claims specified in § 424.44(a) of this chapter.

[78 FR 50968, Aug. 19, 2013]